Optimum Family CHIROPRACTIC INC.

PERSONAL INFORMATION

Name: _____ Preferred Name: _____ Date: MM/DD/YYYY

Birthday: MM/DD/YYYY Age: ____

Address: _____

City: _____ Prov. _____ Postal Code: _____

Home #: _____ Cell #: _____ Work #: _____

E-Mail Address: _____

Occupation: _____ Employer: _____

Marital Status: S○ D○ W○ M○ Spouse / Partner's Name: _____

Children

Name _____ Age: ___ Gender: M○ F○ Name _____ Age: ___ Gender: M○ F○

Name _____ Age: ___ Gender: M○ F○ Name _____ Age: ___ Gender: M○ F○

Who may we thank for referring you to our office? or How did you choose us?

- ☐ Family/ Friend (name) _____
- ☐ Facebook
- ☐ Website
- ☐ Workshop (which group) _____
- ☐ Health Practitioner _____
- ☐ Walk-in
- ☐ Print Advertisement
- ☐ Other _____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? No○ Yes○ Date of last visit: _____

Has a family member previously seen a chiropractor? No○ Yes○ if yes, Spouse _____ Child_____

Name of chiropractor: _____

Reason for seeing them: _____

Describe your experience? _____

How frequently did you go for adjustments? _____

What made you decide not to return to see them? _____

IMPORTANT NOTE:

Today's visit will be focusing on assessing the health of your spine and nerve system. Your central nerve system (brain and spinal cord) is the master controller of your body. Everything in your life is processed and controlled by your nerve system, therefore your health and overall quality of life is dependent on proper function and communication . Due to the close relationship with your spine, if your spine is misaligned and degenerating, it can interfere and alter the function of your nerve system (SUBLUXATION). The result of this miscommunication between your brain and body in some cases is pain or discomfort but it can have broader, more serious effects such as energy loss, fatigue, depression, immune problems, digestive problems, high blood pressure and many more. Many times, subluxations are affecting your health long before symptoms show up. By continuing to fill out this form, we will understand how subluxations may already be affecting your health and quality of life.

For Office Use Only

CORE:	Hx:	G:
C:		
L:		

CURRENT PREGNANCY – Are you pregnant? ◯ No ◯ Yes; if yes, fill out the gray section below

Due Date: ___ Current # of weeks pregnant: _____

Please list of the names of practitioners you see: OBGYN/Hospital? _____ Midwife: _____Doula _____ Naturopath: _____

Are/will you be attending a prenatal class with or without your spouse? ◯ No ◯ Yes If yes, which one? _____

Do you currently participate in a prenatal exercising/ yoga program? ◯ No ◯ Yes

Are you taking dietary supplements? ◯ No ◯ Yes If yes, which ones? :_____

Food intake (describe your diet): _____

_____

Sleep quality: How many hours? ____ Continuous? ◯ No ◯ Yes

What position?_____ Use pillows (body)? ◯ No ◯ Yes

How many times a night do you wake to pee? ___

Job details: What type of work do you do? Office work (sedentary) ____ Physical labour ____ Homemaker _____

Office - hours seated? _____ Commuting time? _____ Drive or transit?_____ Opportunity to move/stretch? ◯ No ◯ Yes

Physical - hrs on feet? _____ Commuting time? _____ Drive or transit? _____ Opportunity to rest/stretch? ◯ No ◯ Yes

Intensity of physical activity? ☐ Light ☐ Moderate ☐ Heavy

PREVIOUS PREGNANCY and BIRTH HISTORY

How many pregnancies have you had? _____ IF this is your first pregnancy mark N/A

Have you had any miscarriages? ◯ No ◯ Yes How many? ____

During any pregnancy did you:

Smoke? ◯ No ◯ Yes How much? _____

Drink? ◯ No ◯ Yes How much? _____

Any ultrasounds or other radiation? ◯ No ◯ Yes

If so, how many and for what reasons?_____

Were there any invasive procedures during the pregnancy (amniocentesis, CVS etc.)? ◯ No ◯ Yes

Please explain _____

Trauma/ illness during pregnancy _____

Please describe any emotional stress the mother experienced during the pregnancy: _____

_____

Position during labour: ☐ On back ☐ Side ☐ Sitting ☐ Standing

Did the mother have an episiotomy? ◯ No ◯ Yes

Was monitoring used? ☐ Internal ☐ External

Location of birth? ☐ Home ☐ Hospital

Birth assistants? ☐ Midwife ☐ Doula ☐ Medical Doctor ☐ None

How many hours did labour last? _____ Active labour? _____ Pushing time? _____

Was labour induced? ◯ No ◯ Yes Reason? _____

Was the mother administered any drugs? ☐ Epidural ☐ Morphine ☐ Other _____

Was there any intervention used during birth? ☐ No ☐ Yes ☐ Forceps ☐ Caesarean ☐ Vacuum extraction

Was there any evidence of birth trauma to the infant? Check all that apply:

☐ Bruising ☐ Stuck in birth canal ☐ Respiratory depression

☐ Odd shaped head ☐ Fast or excessively long birth ☐ Cord around neck

Were there any other complications during birth or Congenital anomalies/ defects present? ◯ No ◯ Yes

Please explain:_____

REPRODUCTIVE HEALTH HISTROY

Age of 1st menstruation: _____ How heavy? ◯ Light ◯ Moderate ◯ Heavy

Pain? ◯ No ◯ Yes If yes, do you use medication? ◯ No ◯ Yes

Cramps? ◯ No ◯ Yes If yes, do you use medication? ◯ No ◯ Yes

Headaches? ◯ No ◯ Yes If yes, do you use medication? ◯ No ◯ Yes

Contraception? ◯ No ◯ Yes If yes, Age of start? _____ Duration? _____

HISTORY OF SPINAL TRAUMA

Sports activities you participated in as a child (i.e., skiing, dance, gymnastics, hockey, etc.) _____

_____

How active is your lifestyle?: ◯ Slightly active ◯ Moderately active ◯ Very active

List any injuries (i.e., falls, sprains, broken bones): _____

HEALTH CONCERNS – FILL IN ALL AREAS

Please check (√) all that you have experienced in the last 12 months and indicate is you were experiencing them before pregnancy or if they are pregnancy related:

	Before	Pregnancy	After		Before	Pregnancy	After
ADD/ADHD	☐	☐	☐	Hand/Wrist Pain	☐	☐	☐
Allergies_____	☐	☐	☐	Headaches	☐	☐	☐
Anxiety	☐	☐	☐	Heart Disease	☐	☐	☐
Asthma	☐	☐	☐	Hernias	☐	☐	☐
Back pain	☐	☐	☐	High Blood Pressure	☐	☐	☐
☐Upper ☐Mid ☐Lower				Hip Pain	☐	☐	☐
Balance/Coordination	☐	☐	☐	Insomnia	☐	☐	☐
Bladder	☐	☐	☐	Irregular Cycles	☐	☐	☐
___ Experiencing leakage?	☐	☐	☐	Jaundice	☐	☐	☐
Cancer	☐	☐	☐	Kidney issues	☐	☐	☐
Chest Pain	☐	☐	☐	Knee/Ankle/Foot Pain	☐	☐	☐
Chronic Cough	☐	☐	☐	Menstrual Cramps	☐	☐	☐
Chronic Fatigue	☐	☐	☐	Metabolism issues	☐	☐	☐
Colds	☐	☐	☐	Migraines	☐	☐	☐
Congestion	☐	☐	☐	Neck/Shoulder Pain	☐	☐	☐
Constipation	☐	☐	☐	Pneumonia/Bronchitis	☐	☐	☐
Cramps	☐	☐	☐	Poor Circulation	☐	☐	☐
Depression	☐	☐	☐	Heartburn/Reflux	☐	☐	☐
Diabetes	☐	☐	☐	Reproductive Issues	☐	☐	☐
Nausea	☐	☐	☐	SPD/ Spectrum Disorder	☐	☐	☐
Diarrhea	☐	☐	☐	Skin issues	☐	☐	☐
Dizziness	☐	☐	☐	Sleep Issues	☐	☐	☐
Ear Infections/Aches	☐	☐	☐	Speech Issues	☐	☐	☐
Eczema	☐	☐	☐	Throat issues	☐	☐	☐
Epilepsy/Seizure	☐	☐	☐	Thyroid issues	☐	☐	☐
Eye Pain	☐	☐	☐	Tinnitus/Ringing Ears	☐	☐	☐
Food Sensitivities	☐	☐	☐	Vertigo	☐	☐	☐
Focus/Memory Issues	☐	☐	☐	Other:_____	☐	☐	☐
Gallbladder issues	☐	☐	☐	Other:_____	☐	☐	☐
G.I. Issues	☐	☐	☐		☐	☐	☐

Special Note: Have you taken any medication within the last 24 hours? No ◯ Yes ◯

Please List: _____

Which health condition is your main concern and brought you to our office? _____

On a scale of 1-10 (10 being severe), how bad is the problem? ____ / 10

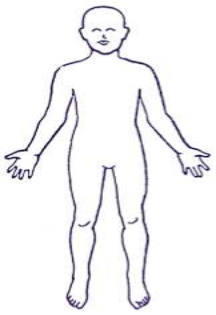
When did it start? _____ How? _____

Is it? getting better ◯ getting worse ◯ staying the same ◯

How would you describe the problem? _____

Are you taking medication for this condition? No ◯ Yes ◯ Please List: _____

Where is the problem? Please circle or draw on the illustrations and explain or describe your present condition in the lines below (i.e. sharp, dull, burning, tight, throbbing...).



Front _____

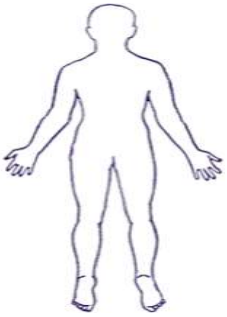
_____

_____

Back _____

_____

_____



What makes it worse? _____

What makes it better? _____

What else have you tried and what were the results? _____

What parts of your life is this condition interfering with: Work ☐ Sleep ☐ Exercise ☐ Family ☐ Social ☐

Positive mental attitude ☐ Hobbies ☐ Other _____

Which part of your life is most important for you to get back to ASAP? _____

Beyond feeling better, what are 3 reasons you want to be healthier?

1) _____

2) _____

3) _____

Fill out ALL areas with detail for the NEXT 3 most concerning conditions that you checked off:

#1: _____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/ 10

When did it start? _____ How? _____

Is it? getting better ◯ getting worse ◯ staying the same ◯

How would you describe the problem? _____

Are you taking medication for this condition? No ◯ Yes ◯ Please List: _____

#2: _____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/ 10

When did it start? _____ How? _____

Is it? getting better ◯ getting worse ◯ staying the same ◯

How would you describe the problem? _____

Are you taking medication for this condition? No ◯ Yes ◯ Please List: _____

#3:_____

On a scale of 1-10 (10 being severe), how bad is the problem? ____/ 10

When did it start? _____ How? _____

Is it? getting better ○ getting worse ○ staying the same ○

How would you describe the problem? _____

Are you taking medication for this condition? No ○ Yes ○ Please List:_____

Your Injury/ Surgery History

Have you had any surgery? (Please include all surgeries including C-Section)

1. Type_____ Date: _____

2. Type_____ Date: _____

Accidents and / or injuries: auto, work related or other (especially those related to your present problems).

1. Type:_____ Date: _____ Hospitalized: ○ No ○ Yes

2. Type:_____ Date: _____ Hospitalized: ○ No ○ Yes

Informed Consent

Chiropractic care has been proven to be safe, both clinically and scientifically. The risk of injuries and complication is so small that Chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few "side effects" associated with it and we feel that it is responsible to let you know:

1. Research shows that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.
2. While extremely rare, there have been reports of ligament sprains and rib fractures.

☐ I have read and understand the above consent. If I have any questions or concerns, I will discuss them with my Chiropractor.

☐ I understand that research and training is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes and understand that audio or video recordings may occur from time to time. (Your personal privacy is very important to us. We will not release any personal information).

☐ I consent to the care recommended by my Chiropractor and extend this consent to include all other Chiropractors in this office.

Your name: _____ Signature: _____ Date:_____

Witness: _____

SAVE RESET PRINT EMAIL